WOMEN'S HEALTH

ParaGard® Patient Assistance Program

825 Wurlitzer Drive, No. Tonawanda, NY 14120
P 1.800.322.4966 F 1.877.843.8790 www.paragard.com

Our goal is to help you provide ParaGard® for your low-income patients who do not have insurance coverage for ParaGard®. We have streamlined the application process so that you will be able to receive ParaGard® quickly for these patients. To initiate the process, you and your patient must complete the application form on the back of this page. Simply mail or fax the completed form to the address above. If this is the first time your office is ordering ParaGard®, you will also be asked to fill out a business application form and to submit a copy of your healthcare professional's state license.

You may also call us beforehand, at 1-800-322-4966, to discuss whether a specific patient is likely to be eligible for assistance.

A case coordinator will review the completed application within 5-10 business days from the time of receipt. We will then notify you and your patient in writing of her eligibility status. If the application is approved, one ParaGard® will be sent directly to your office for the patient. A signature is required at the time of delivery.

Who may qualify for Patient Assistance for ParaGard®

For financial assistance, your patient must meet these basic requirements:

- She does not have private or government health insurance coverage for ParaGard®
- She meets income criteria established by the Federal Poverty Guidelines
- She is a citizen or documented resident of the U.S.

The FEI Women's Health Patient Assistance Program is voluntary and may be changed or ended at any time.

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PATIENT INFORMATION

First name MI Last name

Street address Apt #

City State Zip code

( ) Phone Email

☐☐/☐☐/☐☐ Date of birth (mm/dd/yy)

I guarantee that I do not have insurance coverage for ParaGard®
❑ Yes ❑ No

Number of children _____

Current gross annual household income $ _____

Number of household members dependent on income _____ (including patient)

Patient's Verification and Signature

I promise that the information on this form is correct and complete. If needed, FEI Women's Health LLC may request and obtain information about my or my family's income to ensure eligibility for this program and/or to ensure the accuracy and completeness of this application. I understand that the FEI Women's Health ParaGard® Patient Assistance Program has the right to modify or discontinue this program and its eligibility requirements, or to terminate assistance, at any time and without prior notice. I understand that assistance depends upon my ability to meet the eligibility criteria for the program. I understand that my personal information shown on this form will not be used for any purpose other than for the FEI Women's Health ParaGard® Patient Assistance Program unless I give written consent, or it is required by the government, or if FEI Women's Health first removes my name and any other identifying information.

Patient's signature _____ Date _____

HEALTHCARE PROFESSIONAL INFORMATION

First name MI Last name

Title

Facility

Street address Suite/Floor

City State Zip code

( ) ( ) Phone Fax

Office contact name

Tax ID#:

Type of Practice: ❑ Public ❑ Private

Number of healthcare professionals in this practice _____

Number of healthcare professionals who place ParaGard® _____

Interested in ParaGard® placement training ❑ Yes ❑ No

Product Distribution Information

ParaGard® will be shipped directly to the healthcare professional's office address at left. A signature is required at time of delivery.

Office hours: _____

Special delivery instructions: _____

Healthcare Professional's Verification and Signature

To the best of my knowledge, this patient does not have insurance coverage (including Medicaid, county-funded assistance, or other public programs) for ParaGard®. No claim may be made to any third party payer for payment of ParaGard® provided by this Patient Assistance Program. The ParaGard® received for this patient may not be sold or traded, may not be returned for credit, and is not a sample. I understand that the FEI Women's Health ParaGard® Patient Assistance Program has the right to modify or discontinue this program and its eligibility requirements, or to terminate assistance, at any time and without prior notice.

Please indicate that you agree to these terms by signing below. Your signature confirms that there is a valid medical need for this patient's prescription for ParaGard®.

Healthcare professional's signature Date

Rx Patient name

Product State license

(If this is your first time ordering from ParaGard Direct, you must submit a copy of your license.)